



# MAGISTRATES COURT *of* TASMANIA

## CORONIAL DIVISION



---

## **Record of Investigation into Death (Without Inquest)**

*Coroners Act 1995  
Coroners Rules 2006  
Rule 11*

I, Olivia McTaggart, Coroner, having investigated the death of Mark Andrew O'Brien

### **Find, pursuant to Section 28(1) of the Coroners Act 1995, that:**

- a) The identity of the deceased is Mark Andrew O'Brien;
- b) Mr O'Brien died as a result of injuries sustained following a motorcycle crash on 13 January 2017 at Kalang Avenue, Lenah Valley in Tasmania;
- c) The cause of death of Mr O'Brien was multiple traumatic injuries of head and chest; and
- d) Mr O'Brien died on 18 January 2017 at the Royal Hobart Hospital, Hobart in Tasmania.

In making the above findings, I have had regard to the evidence gained in the comprehensive investigation into Mark Andrew O'Brien's death. The evidence comprises a police report of death; a detailed report by the crash investigator; an opinion of the forensic pathologist as to the cause of death; police and witness affidavits; medical records and reports; and forensic evidence.

Mark Andrew O'Brien was born in Hobart, Tasmania on 13 November 1974 and was 42 years of age at his death. He lived at 9/18 Clydesdale Avenue, Glenorchy. His parents are Judith Lorraine O'Brien and Michael David O'Brien. He was never married and he did not have any children. He worked as a computer programmer.

The evidence indicates that Mr O'Brien may have started driving in his early 20s. He owned a Mitsubishi Magna for a long time and was described as a careful driver. In 2015 Mr O'Brien purchased a blue Honda 125cc motorcycle (registration number A994V). This was his first motorcycle. Mrs O'Brien stated that "he looked confident riding it" and that Mr O'Brien never mentioned having any issues with it.

At the time of the crash, Mr O'Brien was fully licensed to drive motor vehicles and had a novice P1 licence to drive motorcycles. His motorcycle was registered.

On Friday 13 January 2017, Mr O'Brien spent the earlier part of the day at home. His neighbour, Shirley Wiggins, spoke to him in the morning when he was washing his car. She described him as being his ordinary self that morning. Later, at around mid-afternoon, Ms Wiggins was at a neighbour's house when she saw Mr O'Brien ride off on his motorcycle.

At around 4.00pm, Mr Nicholas Turner, was driving home in his green 1999 Mazda Bravo (registration number B58BW) after finishing work in North Hobart. In his affidavit for the investigation, he said that he was driving west along Kalang Avenue towards Barossa Road at about 50 km/h. He described the road as dry with overcast conditions. He was wearing sunglasses at the time and noted that there was no glare.

As he was navigating a sweeping right-hand bend, Mr Turner suddenly saw a blue motorcycle with a single rider (Mr O'Brien) approaching him. The rider did not appear to be travelling at excessive speed but he was not in control of the vehicle. The motorcycle was wobbling and was one to two feet over the centre line on Mr Turner's side of the road. Mr Turner had less than a second to react before the motorcycle impacted with the driver's side of the vehicle. It was a solid impact with a loud bang.

After impact, Mr Turner pulled over on the left side of the road. He got out quickly and ran up to where Mr O'Brien had come to rest, face down on the middle of the road with his helmet still on. Several motorists stopped and assisted. A male approached and indicated that he was a nurse and commenced first aid. Mr Turner also saw two males pick up the motorcycle and move it to the side of the road. Emergency services were contacted.

Mr O'Brien was treated by ambulance personnel at the scene before being transported and admitted to the Royal Hobart Hospital at 5.16pm.

In hospital Mr O'Brien was assessed as having severe traumatic injuries of the head, brain and chest. Despite aggressive resuscitative efforts and decompressive craniotomy, he died on 18 January 2017, five days following his crash.

An investigation into the circumstances of the crash was conducted by Senior Constable Kelly Cordwell of Crash Investigation Services. Marks and disturbances on the roadway indicated that the crash occurred on the exit of a sweeping left hand bend (for Mr O'Brien). After the initial impact, the motorcycle travelled east before falling to the ground.

The roadway at Kalang Avenue, Lenah Valley has a general east west orientation. The roadway has a single lane for traffic to travel west and a single lane for traffic to travel east. The east and west bound lanes were divided by a single continuous white line. The west bound lane measured 3.4 metres in width and the east bound lane measured 3.9 metres. Both sides of the road were bordered by bushland. The speed limit in the area of the crash was 60km/h. The east bound lane (direction of travel for Mr O'Brien) was bordered by Armco railing. The weather was observed by Senior Constable Cordwell to be fine, warm and dry.

Crash reconstruction and analysis conducted by Senior Constable Cordwell indicated that the motorcycle was travelling between 20 and 25km/h when it was sliding along the road surface. While an accurate speed calculation could not be undertaken, it was clear from the scene that the speed at which the motorcycle was travelling was not excessive.

The motorcycle was inspected by Transport Inspector, Noel Clark, who concluded that it was in a maintained roadworthy condition prior to the crash and reflective of a low mileage, late model vehicle.

In her investigation, Senior Constable Cordwell noted that Mr Turner's green Mazda Bravo appeared to be in a road worthy condition. The tyres all displayed good tread and were inflated. The vehicle was also clean and tidy inside with no obvious obstructions to the driver's visibility or ability to drive the vehicle safely. She concluded that Mr Turner's vehicle was not the primary contributing factor in the collision. Senior Constable Cordwell noted that both vehicles sustained damage consistent with the collision.

An external examination was conducted on Mr O'Brien on 19 January 2017 by pathologist, Dr Donald Ritchey. Dr Ritchey concluded that Mr O'Brien died as a result of multiple traumatic injuries of head and chest sustained in a motorcycle crash. I accept Dr Ritchey's opinion as to cause of death. Toxicology testing of samples of Mr O'Brien's blood obtained during hospital admission revealed drugs consistent with medical therapy but no alcohol or drugs of abuse.

Toxicology testing of Mr Turner's blood sample was conducted by forensic scientist, Miriam Connor, between 19 January 2017 and 1 March 2017. THC-COOH (inactive cannabis metabolite)

was identified in the absence of THC (the active constituent of cannabis). According to Ms Connor, there would be no potential for driving impairment as a result of THC-COOH. Diazepam was detected at a therapeutic level. Mr Turner confirmed that this drug had been prescribed to him and he had taken the recommended dose. There is no evidence to suggest that the ingestion of this drug had any negative effect on the outcome of this crash. He also stated that he smoked cannabis infrequently but had not consumed any on the day of the crash.

Both drivers returned negative results for alcohol. Mr O'Brien had ketamine and midazolam present in his blood, however, these medications were administered as a result of medical treatment and were not present in his system at the time of the crash.

Both Mr O'Brien and Mr Turner were licensed appropriately at the time of the crash and their vehicles were registered. Both vehicles were in a roadworthy condition at the time of the collision.

The roadway was in good condition and no road debris was located to account for loss of control on behalf of Mr O'Brien. The weather at the time was fine and clear. There was no evidence at the scene to indicate that either vehicle involved was travelling at an excessive speed at the time of the crash.

From the evidence of Mr Turner and scene examination, it is evident that Mr Turner had insufficient perception to reaction time to take any form of evasive action to avoid the collision.

The actual reason for Mr O'Brien losing control of his motorcycle is unknown. I am satisfied that the source of his loss of control could not be attributed to the motorcycle, the roadway or Mr Turner's manner of driving. This only leaves the actions of Mr O'Brien as the contributing factor in this collision. Mr O'Brien was familiar with the roadway having lived in the area for a number of years. However, he had only been riding motorcycles for a relatively short time which may have contributed to his loss of control. Upon losing control, Mr O'Brien collided into Mr Turner's vehicle which resulted in traumatic injuries to his head and chest.

### **Findings, Comments and Recommendations**

The circumstances of Mr O'Brien's death do not call for any recommendations pursuant to section 28 (2) of the *Coroners Act 1995*.

I thank Senior Constable Kelly Cordwell for her highly competent investigation and report.

I extend my sincere condolences to Mr O'Brien's family and loved ones on their loss.

**Dated:** 17 September 2019 at Hobart in the State of Tasmania.

**Olivia McTaggart**

**Coroner**